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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Mark Daniel Cook, M.D.** **1425 West H St. Ste. 200** **Oakdale, CA 95361** **Physician's and Surgeon's Certificate No. A 60965,** Respondent.	Case No. 800-2017-039585 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 2, 1996, the Medical Board issued Physician's and Surgeon's Certificate Number A 60965 to Mark Daniel Cook, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 729 defines sexual exploitation by physicians, and others, and states:

> (a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor recommended by a third-party physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor is a public offense:

(1) An act in violation of subdivision (a) shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the offender has no prior conviction for sexual exploitation, shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(3) An act or acts in violation of subdivision (a) with two or more victims shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(4) Two or more acts in violation of subdivision (a) with a single victim, when the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(5) An act or acts in violation of subdivision (a) with two or more victims, and the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000).

For purposes of subdivision (a), in no instance shall consent of the patient or client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

(1) "Psychotherapist" has the same meaning as defined in Section 728.

(2) "Alcohol and drug abuse counselor" means an individual who holds himself or herself out to be an alcohol or drug abuse professional or paraprofessional.

(3) "Sexual contact" means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in Section 243.4 of the Penal Code.

(d) In the investigation and prosecution of a violation of this section, no person shall seek to obtain disclosure of any confidential files of other patients, clients, or former patients or clients of the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in a professional partnership or similar group has sexual contact with a patient in violation of this section, another physician and surgeon, psychotherapist, or alcohol and drug abuse counselor in the partnership or group shall not be subject to action under this section solely because of the occurrence of that sexual contact.

6. Section 726 defines sexual abuse, misconduct, or relations with a patient or others, and states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division or under any initiative act referred to in this division.

(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

7. Excessive prescription or administration of drugs is defined in Section 725, and states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

8. Unprofessional conduct is defined in Section 2234, and states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

9. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

10. Section 2228.1, subdivision (a)(1)(A) provides the means for a licensee to disclose probation status, and states, in pertinent part,

"...the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

DEFINITIONS

11. Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall® and other stimulants are contraindicated for patients with a history of drug abuse.

12. Quetiapine (Seroquel XR®) is indicated in adults for (1) adjunctive therapy to antidepressants in major depressive disorder; (2) acute depressive episodes in bipolar disorder; (3) acute manic or mixed episodes in bipolar I disorder, as either monotherapy or adjunct therapy to lithium or divalproex; (4) maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex; and (5) schizophrenia. It is also indicated in children and adolescents (10-17 years) for acute manic episodes in bipolar I disorder, as monotherapy; and in adolescents (13-17 years) for schizophrenia. Patients should be periodically reassessed to determine the need for treatment and the appropriate dose. Seroquel XR® is not approved for use in pediatric patients under ten years of age. The most commonly observed adverse reactions in clinical trials for children and adolescents were somnolence, dizziness, fatigue, increased appetite, nausea, vomiting, dry mouth, tachycardia, and weight gain. Other adverse reactions include increased risk of suicidal thought and behavior in children, Neuroleptic Malignant Syndrome, metabolic changes, hyperglycemia and diabetes mellitus, dyslipidemia, tardive dyskinesia, hypotension, falls, increases in blood pressure in children and adolescents, leukopenia, neutropenia, and agranulocytosis. Quetiapine is a dangerous drug within the meaning of Business and Professions Code section 4022.

13. Lithium carbonate is not indicated for the treatment of conditions other than manic episodes of Bipolar Disorder, and Manic Depressive illness. It is indicated as a maintenance

treatment for individuals with a diagnosis of Bipolar Disorder in order to reduce the frequency of manic episodes and diminish the intensity of those episodes which may occur. Lithium toxicity is closely related to serum lithium levels, and can occur at doses close to therapeutic levels. Lithium carbonate is a dangerous drug within the meaning of Business and Professions Code section 4022.

14. Divalproex sodium (Depakote®) is an anticonvulsant used to treat seizure disorders, manic episodes associated with bipolar disorder, and to prevent migraine headaches in adults and children 10 years of age and older. Depakote® is not indicated for treatment of conditions other than seizure disorders, manic episodes associated with bipolar disorder, and migraine headache prevention. Side effects can be serious and sometimes fatal, including continuing liver damage despite stopping taking the drug. Fatal liver damage is especially likely in children younger than two years old. Other side effects include, but are not limited to, fatal pancreatic inflammation, suicidal thoughts or actions, bleeding problems, high ammonia blood levels, low body temperature, allergic reactions, drowsiness or sleepiness. Depakote is a dangerous drug within the meaning of Business and Professions Code section 4022.

15. Acetaminophen and codeine (Tylenol® with codeine, Tylenol 3®) is a combination of two medicines used to treat moderate to severe pain. Codeine is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of codeine. Codeine has a high potential for abuse. Codeine is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations.

16. Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly

prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

17. Alprazolam (Xanax®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

19. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The Drug Enforcement Administration ("DEA") has identified opioids, such as oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011

Edition), at p. 41.) Respiratory depression is the chief hazard from all opioid agonist preparations.

20. Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated phentermine HCL is used as a short term adjunct in a regiment of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

FACTUAL ALLEGATIONS

21. ***PATIENT A***[1]

a) In 2015, Patient A had sole custody of her 7-year-old daughter (Patient B), after being widowed. In approximately 2015, Patient A married Respondent. Respondent and Patient A conceived a son by frozen embryo transplantation who was born in February of 2017.

b) According to Respondent's medical billing records, Patient A saw Respondent for medical treatment while she was pregnant on or about January 17, 2017; February 10, 2017; and February 16, 2017 (the day their son was born). However, there are no medical records from Respondent showing any treatment on these dates.

c) On February 23, 2017, one week after Patient A's C-section delivery, Respondent treated her for an incisional hernia and referred her to a surgeon.

d) On or about April 13, 2017, Patient A was seen by Respondent for a complete annual exam, including a breast and pelvic exam. She was noted to have edema from her recent pregnancy and delivery, and was given Pitocin IM and Reglan. This is the first and only annual exam noted in Respondent's medical records.

e) On or about September 5, 2017, Respondent treated Patient A for a rash and a history of allergies.

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[1] Patients are referred to by letter to preserve their privacy.

f) Patient A filled the following prescriptions for controlled substances, issued by Respondent:

Date	Prescription	Dose	Quantity	Days Supply
11-17-2015	Acetaminophen-Codeine Phosphate	300 mg/ 60 mg	100	17
2-25-2016	Zolpidem Tartrate	10 mg	30	30
4-14-2016	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	60	7
5-4-2016	Alprazolam	2 mg	90	30
6-2-2016	Zolpidem Tartrate	10 mg	30	30
6-13-2016	Diazepam	10 mg	90	30
7-24-2016	Zolpidem Tartrate	10 mg	30	30
10-11-2016	Alprazolam	2 mg	90	30
12-7-2016	Zolpidem Tartrate	10 mg	90	90
12-7-2016	Diazepam	10 mg	90	30
2-18-2017	Oxycodone HCL – Acetaminophen	325 mg/ 5 mg	60	15
3-1-2017	Oxycodone HCL – Acetaminophen	325 mg/ 10 mg	120	30
5-1-2017	Phentermine HCL	37.5 mg	90	90
8-7-2017	Diazepam	10 mg	90	30

g) In addition, Respondent prescribed 30 mg of Adderall® daily to Patient A on or about the following dates: December 10, 2015; August 5, 2016; September 22, 2016; October 5, 2016; November 12, 2016; December 11, 2016; January 6, 2017; February 23, 2017; and March 29, 2017. Respondent also prescribed 37.5 mg of phentermine (quantity 90) to Patient A on or about May 1, 2017, approximately three months after she gave birth to their son.

h) Based on Respondent's November 17, 2015 prescription of codeine phosphate, Patient A was taking approximately 320 to 480 mg of codeine per day.

i) None of Respondent's medical records for Patient A mention the prescriptions listed above. There are no medical records, exams, or definitive diagnoses made related to

Patient A's prescriptions. Respondent's medical records fail to provide any documentation of informed consent, discussion of side effects or alternatives, pain contracts, drug testing, or plans to taper.

j) During his interview with Board Investigators, Respondent disputed Patient A's April 14, 2016 prescription for oxycodone, which stated she was to take 60 pills over the course of 7 days, equating to 8 to 9 pills of 325 mg/ 10 mg of oxycodone per day. Respondent stated that he did not know where the seven days came from in the prescription or how the pharmacist came up with that number.

k) It is the standard of care when prescribing controlled substances to provide clear documentation in the medical record of the performance of a history and physical, along with careful diagnosis and planned management, specialist consultation as needed, obtain informed consent (e.g., pain contract), include tapering plans, consider drug testing, look for adverse side effects, and look for abuse or diversion of medications.

l) Respondent failed to properly prescribe controlled substances to Patient A. Respondent regularly prescribed significant amounts of opiates and benzodiazepines and failed to document any diagnosis in Patient A's medical records. The only diagnoses are inferred from his written prescriptions which state Adderall® is for "ADD," diazepam is for "muscle spasm and stress headaches," and oxycodone is for "severe surgery site pain." The most complete note from the only annual examination on or about April 13, 2017, contains no notations or explanations of his prescriptions of high dose prescriptions of oxycodone. In addition, there is no notation or explanation in Respondent's medical records regarding the reason for prescribing phentermine to Patient A on or about May 1, 2017.

m) It is the standard of care to avoid prescribing opiates and benzodiazepines in combination, due to the increased risk of synergistic effects of sedation, possibility of overdose, respiratory depression, and death. The combination of zolpidem and oxycodone is in the serious interaction category which calls for using an alternative rather than prescribing both consecutively. This is due to the high risk of profound sedation, respiratory

depression, coma, and hypotension. Oxycodone and alprazolam require close monitoring because they both increase sedation. In addition, a physician cannot reasonably be dispassionately objective in prescribing controlled substances to a spouse as multiple factors will sway his clinical judgement, such as pleasing his spouse or subconsciously denying the possibility of serious issues in said spouse.

n) Respondent issued numerous prescriptions of opiates and benzodiazepines in combination to Patient A. For example, on or about December 7, 2016, Respondent prescribed Patient A with 10 mg of zolpidem daily and 30 mg of diazepam daily; such a combination may cause additive central nervous system depression. On or about April 14, 2016, Respondent prescribed Patient A with 10 mg of oxycodone daily. Two weeks and four days later, on or about May 4, 2016, Respondent additionally prescribed Patient A with 30 mg of zolpidem daily. Then, on or about June 2, 2016, Respondent increased Patient A's zolpidem dosage to 10 mg daily and again increased, on or about June 13, 2016, to 30 mg daily. Moreover, on or about December 7, 2016, Respondent prescribed Patient A with 10 mg of zolpidem daily for three months. Approximately two months later, on February 18, 2017, Respondent prescribed Patient A with 10 mg (4-6 pills daily) of oxycodone. Approximately 14 days later, on March 1, 2017, Respondent increased her oxycodone dosage prescribing 120 pills. The dosage of 40 mg of oxycodone daily equates to approximately a morphine equivalent dose of 60 mg daily, which is considered an addictive level with a high risk of overdose and abuse.

o) On or about January 8, 2020, during an interview with Board Investigators, Respondent stated under oath that Patient A's fertility physician "asked me if I would follow [Patient A] and provide for her medications in Oakdale so she wouldn't have to drive each time over to Palo Alto to see him." When asked if the treating fertility physician asked Respondent to write prescriptions for minivelle, progesterone, and letrozole, Respondent stated, "Yes sir, that's correct. Exclusively." However, Patient A's fertility physician informed Board Investigators that he "never allowed, consented, consulted nor directed [Respondent] to prescribe, continue to prescribe, nor treat [Patient A] on his behalf as a

physician. He did not supervise nor allow [Respondent] to continue to prescribe drugs related to fertilization." In addition, Patient A's medical records had no evidence that Respondent was directed by a specialist physician to administer progesterone injections or other fertility treatments.

22. ***PATIENT B***

a) At approximately the age of seven, Patient B became Respondent's stepdaughter after her mother married him in the summer of 2015. Respondent gave Patient B a diamond ring, similar to an engagement ring, and she wore it on her ring finger. Respondent told Patient A that it was a sentimental gift between a father and a daughter.

b) At the age of three, Patient B and/or her biological parents saw an LCSW counselor twice over concerns that Patient B suffered from ADHD[2]. Patient B's biological parents were not interested in medications, and Patient B seemed better at her preschool by the second visit.

c) Respondent's medical records for Patient B comprise of only one visit on or about October 17, 2016. According to Respondent's notes Patient B's history showed a "diagnosis of ADHD at [] hospital at age of two." Respondent's medical records state Patient B was already prescribed 30 mg of Adderall®, taking half a tablet twice daily. However, there are no medical records to support this, and Respondent initiated ADHD therapy on his own. Respondent noted that Patient B's immunization history was "none." However, Patient B's prior medical records show many immunizations from birth to 2013. Respondent's exam notations were normal and his assessment was, "well child, ADHD, sick building syndrome and chronic sinus/allergic rhinitis." Respondent never ordered any laboratory testing or EKG's. Respondent's noted plan was to continue current medications at present dosages.

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[2] Attention deficit hyperactivity disorder (ADHD) is a mental health disorder that can cause above-normal levels of hyperactive and impulsive behaviors. People with ADHD may also have trouble focusing their attention on a single task or sitting still for long periods of time.

d) Patient B obtained the following controlled substances based on prescriptions issued by Respondent:

Date	Prescription	Dose	Quantity	Days Supply
12-10-2015	Mixed Amphetamine Salts	15 mg	8	8
12-29-2015	Mixed Amphetamine Salts	15 mg	30	30
2-2-2016	Mixed Amphetamine Salts	15 mg	30	30
3-1-2016	Amphetamine Salt Combo	30 mg	30	30
4-2-2016	Amphetamine Salt Combo	30 mg	30	30
5-4-2016	Amphetamine Salt Combo	30 mg	30	30
6-13-2016	Mixed Amphetamine Salts	30 mg	30	30
7-6-2016	Amphetamine Salt Combo	30 mg	30	30
8-6-2016	Amphetamine Salt Combo	30 mg	30	30
9-12-2016	Amphetamine Salt Combo	30 mg	30	30
10-11-2016	Amphetamine Salt Combo	30 mg	30	30
11-12-2016	Amphetamine Salt Combo	30 mg	30	30
12-12-2016	Amphetamine Salt Combo	30 mg	30	30
1-10-2017	Amphetamine Salt Combo	30 mg	30	30
2-23-2017	Amphetamine Salt Combo	30 mg	30	30
3-29-2017	Amphetamine Salt Combo	30 mg	30	30
5-1-2017	Mixed Amphetamine Salts	30 mg	30	30
5-9-2017	Amphetamine Salt Combo	30 mg	30	30
6-7-2017	Amphetamine Salt Combo	30 mg	30	30
7-2-2017	Amphetamine Salt Combo	30 mg	60	30
7-28-2017	Dextroamph Sacc-Amph ASP-Dextroam S	30 mg	30	30

e) According to Respondent's medical records, he began prescribing Patient B with 20 mg of Adderall® for ADHD on or about August 28, 2015. The starting dose for Adderall® is typically 5-10 mg. Respondent continued Patient B's Adderall® prescriptions monthly through approximately July of 2017.

f) Respondent's first record of an office visit for Patient B occurred on or about October 17, 2016, over one year after he began prescribing psychotropic medications for her. Respondent failed to obtain a baseline EKG, which most pediatricians would obtain to monitor the slight risk of cardiomyopathy. Respondent failed to perform any laboratory work on Patient B. Laboratory monitoring is necessary, as dosage modification is required based on toxicity and possible issues. Respondent failed to order any confirmatory tests (e.g., Conner Scale[3]), or provide a referral for confirmatory tests that Patient B in fact had ADHD or bipolar disorder.

g) The following day, on or about October 18, 2016, Patient B was seen by a psychiatrist at a children's health medical practice. Respondent and Patient A accompanied her. The history provided was that Patient B was a sweet, social, and hyperactive child, up to the age of seven. After Patient B witnessed domestic abuse between her biological father and mother in approximately 2014, Patient B stopped talking for several months and would only sing and stutter. Patient B then saw a counselor and made significant progress. However, in approximately 2015, Patient B's father committed suicide and her mother (Patient A) married Respondent. When Patient A was approximately five to six months pregnant, Patient B regressed at home and the overall impression was post-traumatic stress disorder (PTSD), with Respondent "managing her medications in their rural community." In addition, Patient B was noted to experience symptoms consistent with Dysphoric Mood Dysregulation Disorder except that they only occurred around Respondent and Patient A, which led more towards symptoms of Oppositional Defiant Disorder with an unspecified

[3] The Conners Comprehensive Behavior Rating Scale (CBRS) is a tool used to gain a better understanding of academic, behavioral and social issues that are seen in young children between ages six to eighteen years old. It is frequently used to assist in the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

Bipolar Disorder. Further counseling was recommended and the psychiatrist noted that Patient B's "emotional, social and family functioning are at high risk for further medical and psychological complications and progression." It was recommended that Adderall® dose reduction be considered based on patient irritability. The psychiatrist recommended quetiapine (Seroqual®) 25 mg at bedtime titrating by 25 mg weekly to a maximum dose of 100 mg nightly. During an interview with Board Investigators, the psychiatrist stated the Respondent initiated the referral and Respondent "did most of the talking at the visit." The psychiatrist advised that Patient B's medications were to be managed by a trained psychiatrist, stating it was beyond the scope of a primary care physician to manage psychotropic medications for a child. The psychiatrist referred Patient B to a physician in Modesto, and provided Respondent with names for therapists. Subsequently, Patient B's referral appointment with the Modesto physician was cancelled and Patient B was thereafter never seen, nor was her medication managed by a trained psychiatrist.

h) That same day, on or about October 18, 2016, Respondent (a primary care physician and not a trained psychiatrist) began managing Patient B's psychotropic medications. Respondent prescribed Patient B quetiapine (Seroqual®) 25 mg, quantity of 120, equating to possibly 1-4 per day, and 25 to 100 mg daily. On or about October 25, 2016, Respondent increased Patient B's dosage of quetiapine to 100 mg daily, with a quantity of 30. Respondent noted that Patient B had an excellent response to quetiapine and suffered from "anxiety/panic/agitation." On or about November 25, 2016, Respondent again increased Patient B's dosage to 200 mg per day, by increasing the dosage quantity to 60. On or about January 6, 2017; February 1, 2017; and March 29, 2017, Respondent continued to prescribe Patient B with 200 mg of quetiapine daily. The psychiatrist who saw Patient B on or about October 18, 2016, had recommended a maximum dosage of 100 mg of quetiapine daily. However, Respondent eventually prescribed Patient B with 400 mg of quetiapine daily. The safety and efficacy of quetiapine is not established prior to the age of ten. Side effects of quetiapine include dizziness, fatigue, blood pressure elevation, lipid elevation, dry mouth, headache and somnolence, QT interval prolongation,

and risk of extrapyramidal (Parkinsonian) side effects. Respondent made no chart notes regarding these prescriptions, made no diagnoses, and failed to follow the recommendations of the psychiatrist.

i) In addition, on or about March 1, 2016, Respondent added more psychotropic medications and prescribed Patient B with 300 mg of lithium, two to three times per day. Patient B was eight-years-old at the time. Respondent began prescribing her lithium without having any diagnosis for bipolar disorder from specialists. Lithium causes significant side effects, including an elevated white cell count, polyuria and polydipsia, dry mouth, hand tremors, confusion, memory issues, headaches, weakness, gastrointestinal symptoms, and EKG changes. Careful monitoring is necessary, especially with blood levels to avoid toxicity, along with kidney and thyroid tests; Respondent failed to perform any of these tests. The lithium prescription was concurrent with the Adderall® prescription, which was increased to 30 mg, on or about March 1, 2016. Of note, lithium combined with Adderall® can cause a serotonin syndrome or increased agitation and high fever. On or about June 13, 2016, Respondent again currently prescribed Patient B 300 mg of lithium and 30 mg of Adderall®.

j) On or about June 2, 2016, Respondent added more psychotropic mediations and prescribed Patient B 500 mg of Depakote twice daily, with a quantity of 60. Depakote is not recommended for children under the age of ten, due to serious side effects, including but not limited to, permanent liver damage, life-threatening pancreatitis, suicidal thought, and blood and metabolic disorders. Patient B was eight at the time.

k) In prescribing of all of these psychotropic agents to Patient B, Respondent made no chart notes discussing any of these medications, except one mention that Patient B was already taking Adderall® during the one office visit on or about October 17, 2016. Respondent failed to make any diagnoses regarding Patient B. Respondent failed to follow the recommendations of the psychiatrist, and against her recommendation he began solely managing Patient B's psychotropic prescriptions despite such management being beyond the scope of his practice. The psychiatrist recommended quetiapine with a maximum dose

of 100 mg daily; instead, Respondent increased Patient B's dosage up to 400 mg daily and added additional psychotropic medications (Lithium and Depakote). Respondent failed to properly monitor Patient B while she was taking the numerous medications he prescribed. Respondent's prescribing of numerous psychotropic medications to Patient B was an extreme departure from the standard of care and caused definite harm to Patient B both physically and psychologically.

l) During his interview with Board investigators, Respondent claimed that he did not know what occurred during the meeting with the psychiatrist because he spent the whole time outside playing with Patient B, while the mother (Patient A) spoke with the psychiatrist. Nonetheless, Respondent told Board investigators that he provided the Seroquel prescription based upon the recommendations of the psychiatrist, and the psychiatrist herself told Board investigators that Respondent had done "most of the talking" during the visit.

m) On or about August 20, 2017, Patient A and Respondent separated.

n) On or about September 12, 2017, Patient B told her mother (Patient A) that she wished she could have locked her bedroom door at Respondent's home. When Patient A asked why, Patient B responded that Respondent would not let her use the bathroom when he slept in her bed and that Respondent slept in her bed with her wearing only his underwear. Patient B went on to explain that Respondent would put his hands together and, "get comfortable." When asked what "getting comfortable" meant, Patient B put both of her hands together in a praying motion, laid down on her back, placed her clasped hands in her genital area and started "gyrating" her body up and down while shifting her head left to right. Patient B also reported this to her nanny/house cleaner.

o) On or about September 14, 2017, Patient A drove Patient B to Child Protective Services (CPS) in Modesto and told Patient B that she needed to tell them what happened. Patient B responded, "I don't want to tell them that, I don't trust you." Against her will, Patient B was escorted by Patient A into CPS in order to file a report. Patient B was interviewed by a CPS staff member, and when asked about her private parts, she refused to name them.

When Patient B was asked about her private parts, she immediately stated that, "her stepdad [Respondent] did not do any of those things." When questioned about what "those things meant," Patient B stated that Respondent would not sleep in the king-sized bed with her mother. Instead he slept in her bed with her for two hours each night. She denied that anyone had ever touched her "private parts or made her feel uncomfortable." She reported that if someone did, she would tell her mother. The CPS staff member concluded the interview and returned Patient B to her mother (Patient A). After they left CPS, Patient A and Patient B returned and requested that CPS re-interview Patient B. The CPS staff refused, "not being sure what the mother had discussed with [Patient A] and then coming back." The CPS staff member stated another employee would follow-up with them.

p) On or about September 18, 2017, another CPS employee interviewed Patient B at her school. Patient B stated that she was frightened, but the CPS employee calmed her fears and told her that she was not in trouble, but that he would like to ask her some questions. Patient B told CPS that Respondent liked to sleep in her bedroom, and he does not like sleeping with her mother (Patient A). Patient B stated that Respondent has never touched her inappropriately; however, she has seen him many times while sleeping put his hands in a "prayer way" between his legs and would be shaking. Patient B demonstrated what was described as convulsing. Patient B stated that she was always scared when Respondent put his hands between his legs. Patient B stated that she was able to see Respondent's hands because the night light was always on.

q) On or about September 23, 2017, an Oakdale Police Officer responded to Patient A's report of Respondent's alleged lewd and lascivious acts with a child. The officer asked Patient A why Respondent slept in Patient B's bed and Patient A responded that during the past two years that she had been married to Respondent, they had only had sexual intercourse approximately 12 times.

r) On or about October 5, 2017, an Oakdale Police Department detective interviewed Patient A. She reported that Respondent took a special interest in Patient B and chose to sleep in

her bedroom at night. Patient B began wetting herself and defecating in her pants. Respondent and Patient A's relationship became strained over their two-year marriage and Respondent showed no interest in being intimate with Patient A. After Respondent moved out of the home, Patient B told her about Respondent "convulsing" at night in her bed with his hands between his legs.

s) On or about October 11, 2017, the Stanislaus Family Justice Center conducted a recorded interview with Patient B, who was nine-years-old at the time. Patient B stated that she was "really thinking that [Respondent] was going to be a good dad," but when she was approximately seven-years-old, Respondent began coming into her bedroom at bedtime and closed the door behind him. Respondent had Patient B recite the prayer, "Now I lay me down to sleep," take off his clothes (leaving on his underpants), and then would sit in the bed with his hands in his underpants, touching his "private parts." Patient B described that Respondent would move and make "convulsing" motions, and he would moan loudly. Patient B stated that Respondent would not allow her to get out of bed and sometimes would place his hand on her shoulder or stomach. Patient B stated that Respondent did this several times throughout the night, sometimes waking her. When asked how many times this occurred, Patient B replied, "730." When asked if she was scared, Patient B responded that Respondent was 6 foot 4 inches tall and asked the interviewer to put herself in Patient B's place. Patient B stated that her mother (Patient A) was tired and sick during that time because she was pregnant with her baby brother.

t) On October 19, 2017, Patient A made a pre-text call to Respondent with police officers on the line with her. Patient A stated, "I guess I know why you'd never sleep in the same room as me, how could you do this?" Respondent replied by saying something about a housewife show and a referral he may have to give. It appeared to the officer that Respondent did not know whom he was speaking with. Patient A stated, "What are you talking about?" Based on Respondent's tone, the officer thought Respondent seemed to know that authorities were listening to the call. Respondent stated, "Goodbye," and hung up the phone. The next day Respondent provided the officer a typed letter detailing the

pre-text phone call; however, Respondent claimed in his letter that he made statements that he did not in fact make during the recorded call.

u) On February 9, 2018, Patient A took Patient B to a children's hospital. Patient B disclosed that Respondent masturbated next to her. Patient B also disclosed that Respondent would lay behind her, hold her down, and stick his penis in her anus. Then, he would tell her to stay in bed and he would take a shower.

v) On February 20, 2018, when Patient B was approximately nine years old, she was again interviewed. Patient B stated that when they moved in with Respondent he started coming into her bedroom on her first night there. Patient B reiterated that Respondent would make her say the prayer, "Now I lay me down to sleep," and then Respondent would climb into bed with her and "touch his private parts" inside his underwear. She could see him holding his "private parts in his hand" and move while making a "strange moaning noise." Patient B described the movement. Sometimes Respondent would put his hand on her stomach. Respondent would stop after approximately 15 minutes and then fall asleep in her bed. Patient B stated that Respondent did the same thing the next night and "he did more the next time." Patient B described that Respondent came into her room and closed the door, and had her pray with him, and then he made her climb into her bed with him. Respondent "grabbed" Patient B "super fast" and "put [her] on [her] side." He pulled down her pajamas and underwear, Patient B stated that she "tried to get out of there," but Respondent "wouldn't let go of [her.]" Respondent did not say a word. Respondent had a "clear bottle" with clear liquid, and he would put some of it in his hands and rub it "all over" his "private parts." Then, Respondent "put his private parts inside [her] bum." Patient B said it hurt so bad that she felt like she was going to faint. She also felt like she was "going to scream," but she was "so scared that [she] couldn't even scream." Respondent got out of bed and raised his voice, telling Patient B to "stay in bed," and he went to take a shower in her bathroom. Patient obeyed because she was "too scared to move." Patient B felt sticky and uncomfortable after Respondent put his "private part inside her bum." After Respondent finished showering, he got back into bed

with Patient B, and touched his private parts with both hands again, while moaning and moving. Then, Respondent would face away from Patient B and fall asleep. Respondent took showers only after he put his "private part inside of [her] bum." Patient B stated that in the morning, she would find, "little brown particles" in her shower; she cleaned it up with a wet cloth. Patient B explained that Respondent would "only put his private parts inside of [her] bum, like every other night, but he never skipped a night touching his private parts." Patient B stated that her "bum hurt" in the mornings and she would have "accidents" in her pants. Patient B "couldn't wipe" and when she did, there was "blood on the toilet paper." Patient B clarified that she thinks Respondent's private part is "called a penis."

w) On July 2, 2020, Board Investigators interviewed 11-year-old Patient B. Patient B felt that after Respondent married her mother, he "was going to be good because he was nice and he was a doctor." Respondent gave Patient B a ring, and put it on her ring finger. Patient B described that every other night, Respondent would come into her bedroom at night and make her pray with him. She saw him undress down to his underwear and get into her bed, lying next to her. Respondent put both of his hands together and put them in his underwear in his pubic area. She saw him move his hands up and down in short rubs and could feel his body move. Patient B was "frozen" and "felt paralyzed from fear," until she eventually fell asleep. Patient B stated that it lasted for a while, but could not specify a specific amount of time. This occurred for the first time when Patient B was approximately seven years old. On alternate nights, when Respondent did not place his hands in his groin area while in bed with her, Patient B stated Respondent would climb into her bed and make her "bum" or anus hurt. After a while, Respondent stopped and Patient B would be in pain. Respondent would typically get up from her bed and take a shower in her attached bathroom at the "big house," or a bath in the kitchen bathroom in the "little house." Patient B would eventually fall asleep. When she woke up in the morning, Respondent would be gone. Her "bum" would still hurt in the morning and she would be in pain throughout the day and have uncontrollable "accidents," where she

defecated in her underwear. Patient B would then hide her underwear. She only experienced "accidents" on nights that Respondent made her "bum" hurt. Respondent would alternate his behavior, one night touching himself and the next night making her "bum" hurt. Patient B only recalled two times when Respondent did not climb into bed with her. It was during the summer when she was eight, and they stayed in two adjacent cabins by the lake; Respondent and her mother stayed in one cabin and Patient B and her nanny stayed in the other cabin. When they moved back to "the little house," after the summer, Patient B recalled that she slept on an inflatable mattress in the playroom or on the futon in the living room. Patient B told her mother about what Respondent had been doing to her after a couple of weeks had passed and she was confident that Respondent was not returning to her home.

FIRST CAUSE FOR DISCIPLINE

(Sexual Exploitation)

23. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 729, in that Respondent is guilty of sexual exploitation of Patient B. The facts and circumstances are alleged in paragraph 22 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Sexual Misconduct)

24. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 726, in that Respondent committed acts of sexual abuse and misconduct with Patient B. The facts and circumstances are alleged in paragraph 22 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

25. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (b) in that Respondent was grossly negligent in his care and treatment of

Patient A and Patient B, as more particularly alleged in paragraphs 21 and 22 which are hereby incorporated by reference and realleged as if fully set forth herein.

a) Regarding Patient A, Respondent was grossly negligent in his care and treatment of her, including but not limited to: failing to document any history, physical examination, diagnosis, or treatment plan related to his prescribing of multiple controlled substances; failing to discuss side effects or alternatives; failing to make specialist consultations and/or referrals; failing to obtain informed consent; failing to create and maintain a pain contract; failing to include tapering plans; failing to consider and utilize drug testing; failing to follow-up and look for adverse side effects; failing to ensure proper use of the medications; failing to discuss the long period of Adderall® use in his notations; and failing to note and/or explain the high doses of oxycodone he prescribed.

b) Regarding Patient B, Respondent was grossly negligent in his care and treatment of her, including but not limited to: prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist by prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist in the dosage of psychotropic medications; failing to obtain a baseline EKG; failing to request laboratory blood work in order to monitor psychotropic medication dosages and possible toxicity; kidney issues, and thyroid issues; failing to request or administer confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium and Adderall® concurrently; prescribing Depakote when she was seven, which is not recommended to children under the age of ten; prescribing Seroquel when she was seven, which is not recommended to children under the age of ten; increasing the Seroquel dosage from the recommended maximum of 100 mg daily up to 400 mg daily; failing to chart any notes of the psychotropic medications beyond the one note on October 17, 2016 regarding Adderall®; failing to substantiate any diagnoses; failing to properly monitor her on her medications; prescribing

medication to Patient B while she was his step-daughter, when he could not be properly objective; and causing physical and psychological harm to Patient B.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 21 and 22 which are hereby incorporated by reference and realleged as if fully set forth herein.

a) Regarding Patient A, Respondent committed repeated negligent acts, including but not limited to: prescribing opiates and benzodiazepines in combination which is a serious interaction, thereby increasing the risk of synergistic effects of sedation, with the possibility of overdose, respiratory depression and death; prescribing opiates and benzodiazepines while psychiatrists concurrently prescribe alprazolam and amphetamines; prescribing a morphine equivalent does of 60 mg daily, which is an addictive level with a high risk of overdose and abuse; failing to document any history, physical examination, diagnosis, or treatment plan related to his prescribing of multiple controlled substances; failing to discuss side effects or alternatives; failing to make specialist consultations and/or referrals; failing to obtain informed consent; failing to create and maintain a pain contract; failing to include tapering plans; failing to consider and utilize drug testing; failing to follow-up and look for adverse side effects; failing to ensure proper use of the medications; failing to discuss the long period of Adderall® use in his notations; and failing to note and/or explain the high doses of oxycodone he prescribed; and prescribing sedatives to his spouse, when a physician cannot reasonably be dispassionately objective.

c) Regarding Patient B, Respondent was grossly negligent in his care and treatment of her, including but not limited to: prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist by prescribing psychotropic medications; failing to follow the recommendations of the psychiatrist in the dosage

of psychotropic medications; failing to obtain a baseline EKG; failing to request laboratory blood work in order to monitor psychotropic medication dosages and possible toxicity; kidney issues, and thyroid issues; failing to request or administer confirmatory tests for ADHD and/or bipolar disorder diagnosis, prescribing lithium and Adderall® concurrently; prescribing Depakote when she was seven, which is not recommended to children under the age of ten; prescribing Seroquel when she was seven, which is not recommended to children under the age of ten; increasing the Seroquel dosage from the recommended maximum of 100 mg daily up to 400 mg daily; failing to chart any notes of the psychotropic medications beyond the one note on October 17, 2016 regarding Adderall®; failing to substantiate any diagnoses; failing to properly monitor her on her medications; prescribing medication to Patient B while she was his step-daughter, when he could not be properly objective; and causing physical and psychological harm to Patient B.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty)

27. Respondent Mark Daniel Cook, M.D. is subject to disciplinary action under section 2234, subdivision (e), in that Respondent committed an act or acts involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon. The facts and circumstances are alleged in paragraph 21 and are incorporated by reference as if fully set forth. Additional circumstances are as follows:

On or about January 8, 2020, Respondent stated under oath to Board Investigators that Patient A's fertility physician "asked me if I would follow [Patient A] and provide for her medications in Oakdale so she wouldn't have to drive each time over to Palo Alto to see him." Respondent clarified that Patient A's fertility physician asked Respondent to write prescriptions for minivelle, progesterone, and letrozole. Patient A's fertility physician informed Board Investigators that he never allowed, consented, consulted, nor directed Respondent to prescribe, continue to prescribe, nor treat Patient A on his behalf as a physician.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 60965, issued to Mark Daniel Cook, M.D.;

2. Revoking, suspending or denying approval of Mark Daniel Cook, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mark Daniel Cook, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: OCT 0 8 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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